HAWAII STD TREATMENT GUIDELINES FOR ADULTS AND ADOLESCENTS 2004

These guidelines for the treatment of patients with STD=s reflect the 2002 CDC STD Treatment Guidelines and the Region IX Infertility Clinical Guidelines. The focus is primarily on STD=s encountered in office practice. These guidelines are intended as a source of clinical guidance and are not a comprehensive list of all effective regimens. Reportable STDs include chancroid, chlamydia, gonorrhea, PID and syphilis. To report STD infections, request assistance with confidential notification of sexual partners of patients with syphilis, gonorrhea, chlamydia or HIV infection, or to obtain additional information on the medical management of STD patients, call the Hawaii State Health Department at **(808) 733-9281**.

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS
CHANCROID	! Azithromycin **or** ! Ceftriaxone **or** ! Ciprofloxacin[2] **or** ! Erythromycin base	1 g po 250 mg IM 500 mg po bid x 3 d 500 mg po tid x 7 d	
CHLAMYDIA			
Uncomplicated Infections Adults/Adolescents[1]	! Azithromycin **or** ! Doxycycline[2]	1 g po 100 mg po bid x 7 d	Erythromycin base 500 mg po qid x 7 d **or** Erythromycin ethylsuccinate 800 mg po qid x 7 d
Pregnant Women[3]	! Azithromycin **or** ! Amoxicillin **or** ! Erythromycin base	1 g po 500 mg po tid x 7 d 500 mg po qid x 7 d	Erythromycin base 250 mg po qid x 14 d **or** Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** Erythromycin ethylsuccinate 400 mg po qid x 14 d
GONORRHEA Ciprofloxacin and other quinolones should NOT be used for infections acquired in Hawaii, California, Asia, and the Pacific due to increased prevalence of Ciprofloxacin-resistant strain N. gonorrhoeae in these areas. If gonorrhea is documented and it persists or recurs, test-of-cure culture is recommended to ensure patient does not have an untreated resistant-strain *N. gonorrhoeae* infection. Co-treatment for chlamydial infection in patients infected with *N. gonorrhoeae* is recommended unless chlamydial infection is ruled-out using sensitive laboratory test such as NAAT.			
Uncomplicated Infections Adults/Adolescents Pregnant Women	**Either** ! Cefixime[5] **or** ! Ceftriaxone **Plus co-treatment for chlamydia**	 400 mg po 125 mg IM	**Either** Cefpodoxime[5] 400 mg po **or** Spectinomycin[5] 2 g IM **or** Ceftizoxime 500 mg IM **or** Cefotaxime 500 mg IM **or** Cefoxitin 2 g IM with Probenecid 1 g po **Plus co-treatment for chlamydia**
Pharyngeal Infections	! Ceftriaxone	125 mg IM	
PELVIC INFLAMMATORY DISEASE[4,6]	**Parenteral[7]** **Either** **!** Cefotetan **or** ! Cefoxitin **Plus** Doxycycline[2] ! Clindamycin **plus** Gentamicin	 2 g IV q 12 hrs 2 g IV q 6 hrs 100 mg po or IV q 12 hrs 900 mg IV q 8 hrs 2 mg/kg IV or IM followed by 1.5 mg/kg IV or IM q 8 hrs	**Parenteral[7]** Ampicillin/Sulbactam 3 g IV q 6 hrs **plus** Doxycycline[2] 100 mg po or IV q 12 hrs
	Oral Treatment/IM **Either** ! Ceftriaxone **or** ! Cefoxitin with Probenecid **Plus** Doxycycline **With or Without** Metronidazole	 250 mg IM 2 g IM 1 g po 100 mg po bid x 14 d 500 mg po bid x 14 d	
SYPHILIS			
Uncomplicated			
Primary, Secondary, and Early Latent	! Benzathine penicillin G	2.4 million units IM	Doxycycline[2, 13] 100 mg po bid x 2 weeks, **or** Tetracycline[2, 13] 500 mg po qid x 2 weeks **or** Ceftriaxone[13] 1g IM/IV qd x 8-10 d **or**
Late Latent and Unknown duration	! Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM, at 1-week intervals	Doxycycline[2,13] 100 mg po bid x 4 weeks, **or** Tetracycline[2, 13] 500 mg po qid x 4 weeks
Neurosyphilis[14]	! Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	Procaine penicillin G, 2.4 million units IM qd x 10-14 d **plus** Probenecid 500 mg po qid x 10-14 d **or** Ceftriaxone[13] 2 g IM/IV qd x 10-14 d
HIV Infection			
Primary, Secondary, and Early Latent	! Benzathine penicillin G	2.4 million units IM	Doxycycline[2, 14] 100 mg po bid x 2 weeks **or** Tetracycline[2,14] 500 mg po qid x 2 weeks
Late Latent, and Unknown duration[15] **with normal CSF Exam**	! Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM, at 1-week intervals	None
Neurosyphilis[14, 15]	! Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	Procaine penicillin G, 2.4 million units IM qd x 10-14 d **plus** Probenecid 500 mg po qid x 10-14 d
Pregnant Women[15]			
Primary, Secondary, and Early Latent	! Benzathine penicillin G	2.4 million units IM	None
Late Latent and Unknown duration	! Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM, at 1-week intervals	None
Neurosyphilis[14]	! Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	Procaine penicillin G, 2.4 million units IM q d x 10-14 d **plus** Probenecid 500 mg po qid x 10-14 d

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS
BACTERIAL VAGINOSIS			
Adults/Adolescents	! Metronidazole **or** ! Clindamycin cream[10] **or** ! Metronidazole gel	500 mg po bid x 7 d 2% one full applicator (5g) intravaginally qhs x 7 d 0.75% one full applicator (5g) intravaginally qd x 5 d	Metronidazole 2 g po, **or** Clindamycin 300 mg po bid x 7 d **or** Clindamycin ovules 100 g intravaginally qhs x 3 d
Pregnant Women	! Metronidazole **or** ! Clindamycin	250 mg po tid x 7 d 300 mg po bid x 7 d	
EPIDIDYMITIS [4,6]	Likely due to gonorrhea or chlamydial infection ! Ceftriaxone **plus** Doxycycline Likely due to enteric organisms ! Ofloxacin **or** ! Levofloxacin	 250 mg IM 100 mg po bid x 10 d 300 mg po bid x 10 d 500 mg po qd x 10 d	
HERPES SIMPLEX VIRUS[11]			
First Clinical Episode of Herpes	! Acyclovir **or** ! Acyclovir **or** ! Famciclovir **or** ! Valacyclovir	400 mg po tid x 7-10 d 200 mg po 5/day x 7-10 d 250 mg po tid x 7-10 d 1 g po bid x 7-10 d	
Episodic Therapy for Recurrent Episodes	! Acyclovir **or** ! Acyclovir **or** ! Acyclovir **or** ! Famciclovir **or** ! Valacyclovir **or** ! Valacyclovir	400 mg po tid x 5 d 200 mg po 5/day x 5 d 800 mg po bid x 5 d 125 mg po bid x 5 d 500 mg po bid x 3-5 d 1 g po qd x 5 d	
Suppressive Therapy	! Acyclovir **or** ! Famciclovir **or** ! Valacyclovir **or** ! Valacyclovir	400 mg po bid 250 mg po bid 500 mg po qd 1 g po qd	
HIV Infection[12]			
Episodic Therapy for Recurrent Episodes	! Acyclovir **or** ! Acyclovir **or** ! Famciclovir **or** ! Valacyclovir	400 mg po tid x 5-10 d 200 mg po 5/day x 5-10 d 500 mg po bid x 5-10 d 1 g po bid x 5-10 d	
Suppressive Therapy	! Acyclovir **or** ! Famciclovir **or** ! Valacyclovir	400-800 mg po bid-tid 500 mg po bid 500 mg po bid	
HUMAN PAPILLOMAVIRUS			
External Genital / Perianal Warts	**Patient Applied** ! Podofilox[16] 0.5% solution or gel **or** ! Imiquimod[17] 5% cream **Provider Administered** ! Cryotherapy **or** ! Podophyllin[16] resin 10%-25% in tincture of benzoin **or** ! Trichloroacetic acid (TCA) **or** ! Bichloroacetic acid (BCA) 80%-90% **or** ! Surgical removal		**Alternative Regimen** Intralesional interferon **or** Laser surgery
Mucosal Genital Warts	! Cryotherapy **or** ! TCA or BCA 80%-90% **or** ! Podophyllin[16] resin 10%-25% in tincture of benzoin. **or** ! Surgical removal	Vaginal, urethral meatus, and anal Vaginal and anal Urethral meatus only Anal warts only	
LYMPHOGRANULOMA VENEREUM	! Doxycycline[2]	100 mg po bid x 21 d	Erythromycin base 500 mg po qid x 21 d Azithromycin[18] 1 g po qd x 21 d
MUCOPURULENT CERVICITIS[4,6,8]	! Azithromycin **or** ! Doxycycline[2]	1 g po 100 mg po bid x 7 d	Erythromycin base 500 mg po qid x 7 d **or** Erythromycin ethylsuccinate 800 mg po qid x 7 d
NONGONOCOCCAL URETHRITIS[6]	! Azithromycin **or** ! Doxycycline[2]	1 g po 100 mg po bid x 7 d	Erythromycin base 500 mg po qid x 7 d **or** Erythromycin ethylsuccinate 800 mg po qid x 7 d
TRICHOMONIASIS[9]	! Metronidazole	2 g po	Metronidazole 500 mg po bid x 7 d

1 Annual screening for women age 25 years or younger. Nucleic Acid Amplification Tests (NAATS) are recommended. Women with Chlamydia should be rescreened 3-4 months after treatment.
2 Contraindicated for pregnant and nursing women.
3 Test-of-cure follow-up is recommended because the regimens are not highly efficacious (Amoxicillin and Erythromycin) or the data on safety and efficacy are limited (Azithromycin).
4 If gonorrhea is documented and it persists or recurs, test-of-cure culture is recommended to ensure patient does not have an untreated resistant gonorrhea infection.
5 Not recommended for pharyngeal gonococcal infection.
6 Testing for gonorrhea and chlaymdia is recommended because a specific diagnosis may improve compliance and partner management.
7 Discontinue 24 hours after patient improves clinically and continue with oral therapy for a total course of 14 days.
8 If gonorrhea is documented, add a gonorrhea treatment regimen.
9 Documented infection with treatment failure should be evaluated for metronidazole-resistant T. vaginalis. Referral to CDC at (404) 639-8371.
10 Might weaken latex condoms and diaphragms because oil-based; not recommended in pregnancy.
11 Counseling about natural history, asymptomatic shedding, and sexual transmission is an essential component of herpes management.
12 If lesions persist or recur while receiving antiviral therapy, HSV resistance should be suspected and a viral isolate should be obtained for testing.
13 Because efficacy of these therapies has not been established and compliance of some of these regimes difficult, close follow-up is essential. If compliance or follow-up cannot be ensured then patient should be desensitized and treated with benzathine pencillin.
14 Some specialists recommend 2.4 million units of benazthine penicillin G q week for 1 to 3 weeks after completion of initial treatment.
15 Patients allergic to penicillin should be treated with penicillin after desensitization.
16 Contraindicated during pregnancy.
17 Safety in pregnancy has not been well established.
18 Azithromycin may prove useful for treatment in pregnant women but no published data are available regarding its safety and efficacy.